Department of Labor & Industries
Olympia WA 98504

CANCELLATION OF ELECTIVE COVERAGE

Sole Proprietors/Partner, Member of Limited Liability Company (LLC), Member of Limited Liability Partnership (LLP) or For-Profit Corporate Officers

I the undersigned, being either a sole proprietor, partner, member of an LLC or LLP or corporate officer of the corporation listed below, do hereby cancel coverage.

Cancellation for corporate officers is effective 30 days after receipt of this signed cancellation notice, or on request provided that the requested date is at least 30 days after the written notice is received by the department.

Cancellation for sole proprietors, partners, LLC or LLP is effective immediately upon receipt of this signed cancellation notice. Liability for payment of premiums is through the date of cancellation as indicated by written notification from the department.

I understand that if, as a sole proprietor, partner, member of an LLC or LLP or corporate officer(s) at a later date again desire the protection of the Worker's Compensation Act, written application must be submitted to the Department of Labor and Industries and coverage will not become effective until such time as the written application is received by the department.

OWNER COVERAGE as provided by RCW 51.32.030 (each owner, partner, LLC or LLP member must sign to cancel coverage-see back).

Check One Sole prop. ☐ LLC ☐ Partner ☐ LLP ☐	UBI	Account ID
Business name		Phone number ( )
Business address	City	State ZIP + 4

Applicant's name	Date / /	Signature

CORPORATE OFFICER COVERAGE as provided by RCW 51.12.110 (list name and position of all Corporate Officers - see back). Please note when you cancel coverage, you cancel coverage for all corporate officers.

Business name	UBI	Account ID
Business address	City	State ZIP + 4

Name	Title	
Phone number ( )	Date / /	Signature

State Fund Account; MAIL FORM TO:

EMPLOYER SERVICES
DEPARTMENT OF LABOR & INDUSTRIES
PO BOX 44144
OLYMPIA WA 98504-4144
(360) 902-4817

NOTE:→ If your Account ID starts with 700, 701 or 706

Self-Insured Account; MAIL FORM TO:

SELF-INSURANCE SECTION
DEPARTMENT OF LABOR & INDUSTRIES
PO BOX 44892
OLYMPIA WA 98504-4892
(360) 902-6860

CORPORATE OFFICERS, PARTNERS, MEMBERS OF LLC OR LLP

(Note: Corporate Officers must be both shareholders & directors)

UBI	Account ID

Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	
Name	Position	SSN	% of ownership
Signature	Duties	DOB	